

**BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF NEVADA**

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**In The Matter of Charges and**

**Complaint Against**

**STELLA YI CHOU, M.D.,**

**Respondent.**

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**Case No. 08-29655-1**

**FILED**

**FEB 22 2010**

**NEVADA STATE BOARD OF  
MEDICAL EXAMINERS**

**SECOND AMENDED COMPLAINT**

The Investigative Committee of the Nevada State Board of Medical Examiners, composed of Charles N. Held, M.D., Chairman, Benjamin Rodriguez, M.D., Member, and Jean Stoess, M.A., Member, at the time of the filing of the complaint and first amended complaint, by and through Lynn E. Beggs, General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Stella Yi Chou, M.D., hereinafter referred to as Dr. Chou, has violated the provisions of NRS Chapter 630, hereby issues its Second Amended Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Dr. Chou was licensed in active status to practice medicine in the State of Nevada (license no. 11344), at all times alleged herein, was so licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Valley Eye Center, 2931 Tenaya Way, Suite 204, in Las Vegas, Nevada originally opened in approximately August 2006 as "Clinique Optique". On or about October 5, 2006, Valley Eye Center began providing refractive surgery to correct refractive errors of the eye, more commonly known as "Lasik." The practice of Valley Eye Center was limited exclusively to the providing of Lasik.

3. The owner and administrator of the facility was purported to be Anamika Jain, M.D. Dr. Anamika Jain is married to Vikas Jain. Dr. Anamika Jain is not an ophthalmologist. Dr. Anamika Jain's specialty is shown in the Board's records to be Rehabilitation Medicine.

1           4.       Vikas Jain had been licensed as a physician, specializing in ophthalmology, in Ohio,  
2 New York, and Florida. On November 14, 2005, the State Medical Board of Ohio revoked Vikas  
3 Jain's license to practice medicine. The Ohio Board's order found, among other things, that Vikas  
4 Jain had committed ophthalmological malpractice upon 22 specific patients, resultant from his failure  
5 to properly preoperatively assess the patients, resulting in ophthalmological surgical errors that caused  
6 harm to the 22 patients. Subsequent to the revocation of his license by the State Medical Board of  
7 Ohio, the medical licenses of Vikas Jain in New York and Florida were surrendered after both states  
8 filed disciplinary proceedings against him based upon the Ohio action. Vikas Jain has no active  
9 license to practice medicine in any state in the United States. Vikas Jain never applied for a license to  
10 practice medicine in Nevada.

11           5.       In October 2006, Dr. Chou began performing refractive eye surgeries at Valley Eye  
12 Center. Dr. Chou lives in Utah and never maintained a residence or presence in Nevada except that  
13 she performed Lasik surgeries at Valley Eye Center. Dr. Chou was not employed by Valley Eye  
14 Center; instead, Dr. Chou was an independent contractor, placed at Valley Eye Center through  
15 CompHealth, a physician recruiting and temporary placement service based out of Salt Lake City, UT.  
16 Dr. Chou was not at Valley Eye Center on a fulltime basis, rather she would fly into Las Vegas at  
17 regularly scheduled intervals to perform Lasik procedures and provide some post-operative care.

18           6.       During the period of time that Dr. Chou performed Lasik surgeries at Valley Eye  
19 Center, the normal practice was that patients were seen at Valley Eye Center for pre-operative  
20 measurements and assessments in preparation for Lasik and to determine if patients were good  
21 candidates for the procedure and would then be scheduled for a Lasik procedure with Dr. Chou.  
22 October 2006 and March 2007, Dr. Chou performed Lasik surgeries at Valley Eye Center; however  
23 there was no licensed ophthalmologist or optometrist on the premises to perform pre-operative  
24 evaluations or assessments in her absence. Pre-operative evaluations were conducted often by non-  
25 licensed individuals, medical assistants, and although many pre-operative measurements and  
26 assessments could be performed by these medical assistants at the direction of a licensed  
27 ophthalmologist or optometrist, some of the pre-operative evaluations could only be performed by a  
28 licensed optometrist or ophthalmologist.

1           7.       Between March 2007 and May 2008 while Dr. Chou was at Valley Eye Center,  
2 Dr. Elise Millie, a licensed optometrist was on the staff of Valley Eye Center and did perform some  
3 pre-operative evaluations and assessments of potential Lasik patients, and if appropriate would  
4 schedule patients for Lasik surgery on days that Dr. Chou would be performing surgeries at Valley  
5 Eye Center.

6           8.       During the time that Dr. Chou was at Valley Eye Center, many of the preoperative  
7 examinations, measurements and assessments were completed by Vikas Jain who was known to  
8 sometimes represent himself to patients as "Dr. Ken." Vikas Jain would perform preoperative  
9 assessments, measurements and examinations of patients' eyes, in part to determine their candidacy  
10 for Lasik surgery. Dr. Chou was not present at Valley Eye Center when medical assistants performed  
11 measurements or when Vikas Jain performed medical examinations and/or assessments on patients'  
12 eyes, and she exerted no supervisory oversight or control over the work of Vikas Jain or the medical  
13 assistants.

14           9.       Dr. Chou would normally fly into Las Vegas the evening before surgeries were to be  
15 performed. Upon arrival in Las Vegas, Dr. Chou would be presented with a pile of patient files for the  
16 surgeries that were scheduled for the following days and she would review the information in the files.  
17 Many of the preoperative assessments, measurements and evaluations contained in the patient files  
18 would have been performed by medical assistants and/or Vikas Jain.

19           10.      The following day and sometimes for multiple days, Dr. Chou would perform Lasik  
20 eye surgeries using a Nidek machine leased by Valley Eye Center. Nidek machines require the use of  
21 precise measurements to assure the proper outcome of the surgery and may not be used on dilated  
22 eyes. Prior to performing surgery on patients scheduled for Lasik procedures, Dr. Chou did not  
23 perform an independent evaluation of each patient to determine whether the patient was an appropriate  
24 candidate for Lasik surgery or if any contraindications to the surgery existed prior to performing the  
25 surgical procedure and would make a final diagnosis and decision to proceed forward with the  
26 procedure solely on the information provided to her by others; often by medical assistants and/or  
27 Vikas Jain only.

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11. Dr. Chou also failed to meet privately and independently with each patient to discuss their impending surgery and to discuss the risks and benefits of the procedure prior to the patients consenting to the surgical procedure, and instead would often meet with a number of patients at a time in a group setting and often a sedative would be provided to patients prior to Dr. Chou discussing the procedure with patients prior to the surgery.

12. Pursuant to this normal mode of practice, Dr. Chou performed Lasik surgery upon the eyes of Patients A, B, C, D, E, F, G, H, I, J, performing no independent evaluation of the patients prior to performing Lasik surgery.

**Count I**

13. Patient A had double vision and wore glasses with prisms. On or about February 7, 2007, Patient A presented to Valley Eye Center for Lasik surgery which was performed by Dr. Chou in the manner described above.

14. NAC 630.040 defines malpractice as failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

15. NRS 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

16. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient A in the manner described.

17. Dr. Chou's treatment of Patient A as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

**Count II**

18. On or about January 12, 2007, Patient B presented to Valley Eye Center for Lasik surgery which was performed by Dr. Chou in the manner described above.

19. During a post-operative visit, Patient B was seen by Vikas Jain who wrote a prescription for Patient D on Dr. Chou's prescription pad for Prednisone and forged Dr. Chou's name on the prescription in the presence of Patient B.

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20. Nevada Administrative Code section 630.040 defines malpractice as “the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

21. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for initiating discipline against a licensee.

22. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient B in the manner described. Additionally, Dr. Chou allowed her prescription pad to be used by an employee of Valley Eye Center, including the issuance of a prescription for Patient B on which Dr. Chou's signature was forged apparently with Dr. Chou's knowledge and assent.

23. Dr. Chou's treatment of Patient B as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

### Count III

24. On or about January 12, 2007, Patient C underwent Lasik surgery to correct nearsightedness at Valley Eye Center. The procedure was performed by Dr. Chou pursuant to the procedures set forth above.

25. Nevada Administrative Code section 630.040 defines malpractice as “the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

26. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for initiating discipline against a licensee.

27. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient C in the manner described above and accordingly her care of Patient C as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

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**Count IV**

28. On or about March 9, 2007, Patient D presented to Valley Eye Center for Lasik surgery. The procedure was performed by Dr. Chou pursuant to the procedures set forth above.

29. Nevada Administrative Code section 630.040 defines malpractice as “the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

30. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for initiating discipline against a licensee.

31. On or about March 6, 2008, Patient D returned to Valley Eye Center for an enhancement procedure due to her eyesight being worse than prior to the surgery. Again, Dr. Chou performed the procedure pursuant to the normal method of practice described above.

32. Patient D developed an inflammation of her eyes post-operatively. Dr. Chou allowed Dr. Millie, an optometrist to write a prescription for Patient D on Dr. Chou’s prescription pad for oral and topical steroids. Dr. Millie forged Dr. Chou’s signature on the prescription and presented the forged prescription to Patient D apparently with Dr. Chou’s knowledge and assent.

34. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient D in the manner described and failed to personally perform any pre- or post-operative examinations and allowed her prescription pad to be used by another individual.

35. Dr. Chou’s treatment of Patient D as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

**Count V**

36. On or about June 29, 2007, Dr. Chou performed Lasik surgery on Patient E at Valley Eye Center pursuant to the procedures discussed above.

37. Nevada Administrative Code section 630.040 defines malpractice as “the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

1 38. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for  
2 initiating discipline against a licensee.

3 39. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under  
4 similar circumstances by physicians in good standing practicing ophthalmology in Nevada when  
5 she performed the Lasik surgery upon Patient E in the manner described and accordingly her care of  
6 Patient E as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary  
7 action being taken against her.

8 **Count VI**

9 40. On or about June 9, 2007, Patient F presented to Valley Eye Center for Lasik surgery  
10 which was performed by Dr. Chou pursuant to the procedures described above Dr. Chou failed to  
11 perform any independent pre-operative examination of Patient H.

12 41. Nevada Administrative Code section 630.040 defines malpractice as "the failure of a  
13 physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under  
14 similar circumstances."

15 42. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for  
16 initiating discipline against a licensee.

17 43. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under  
18 similar circumstances by physicians in good standing practicing ophthalmology in Nevada when  
19 she performed the Lasik surgery upon Patient F in the manner described and accordingly her care of  
20 Patient F as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary  
21 action being taken against her.

22 **Count VII**

23 44. On our about June 28, 2007, Patient G presented to Valley Eye Center for Lasik  
24 surgery which was performed by Dr. Chou pursuant to the procedures described above.

25 45. Nevada Administrative Code section 630.040 defines malpractice as "the failure of a  
26 physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under  
27 similar circumstances."

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47. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient G in the manner described and accordingly her care of Patient G as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

### Count VIII

9           48.     On or about January 3, 2008, Patient H presented to Valley Eye Center for Lasik  
10 surgery. Pursuant to the procedures as described above.

11 49. Nevada Administrative Code section 630.040 defines malpractice as “the failure of a  
12 physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under  
13 similar circumstances.”

14           50. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for  
15 initiating discipline against a licensee.

51. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she performed the Lasik surgery upon Patient H in the manner described and accordingly her care of Patient H as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary action being taken against her.

**Count IX**

22           52.     On or about March 13, 2008, Patient I presented to Valley Eye Center for Lasik  
23     surgery on her left eye. Dr. Chou performed Lasik surgery pursuant to the procedures described  
24     above.

53. Nevada Administrative Code section 630.040 defines malpractice as “the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

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1 54. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for  
2 initiating discipline against a licensee.

3 55. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under  
4 similar circumstances by physicians in good standing practicing ophthalmology in Nevada when  
5 she performed the Lasik surgery upon Patient I in the manner described and accordingly her care of  
6 Patient I as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary  
7 action being taken against her.

8 **Count X**

9 56. On or about March 27, 2008, Patient J presented to Valley Eye Center for Lasik  
10 surgery for the correction of farsightedness. Dr. Chou performed Lasik surgery pursuant to the  
11 procedures described above.

12 57. Nevada Administrative Code section 630.040 defines malpractice as “the failure of a  
13 physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under  
14 similar circumstances.”

15 58. Nevada Revised Statute section 630.301(4) provides that malpractice is grounds for  
16 initiating discipline against a licensee

17 59. Dr. Chou failed to use the reasonable care, skill, or knowledge ordinarily used under  
18 similar circumstances by physicians in good standing practicing ophthalmology in Nevada when she  
19 performed the Lasik surgery upon Patient J in the manner described and accordingly her care of  
20 Patient J as alleged constitutes a violation of NRS 630.301(4) and thus she is subject to disciplinary  
21 action being taken against her.

22 **Count XI**

23 60. The diagnosis and determination of candidacy for Lasik surgery and several of the pre-  
24 operative evaluations performed to make this diagnosis and determination are the practice of medicine  
25 and may only be performed by a licensed ophthalmologist or optometrist.

26 61. Dr. Chou knew that Vikas Jain was not a licensed physician or optometrist in Nevada  
27 and was aware that from August 2006 through March 2007, there was no licensed ophthalmologist

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1 or optometrist at Valley Eye Center performing pre-operative assessments or evaluations or her Lasik  
2 surgery patients.

3 62. In performing Lasik surgeries at Valley Eye Center, Dr. Chou relied often, solely upon  
4 preoperative assessments, evaluations and candidacy diagnoses made by persons whom  
5 Dr. Chou knew were not physicians or optometrists licensed in Nevada. In so doing, Dr. Chou aided,  
6 assisted, and knowingly allowed unlicensed persons, namely Vikas Jain to engage in the practice of  
7 medicine contrary to the provisions of NRS chapter 630.

8 63. Dr. Chou's aiding, assisting, and knowingly allowing Vikas Jain to perform pre-  
9 operative evaluation on patients' eyes that could only be performed by an ophthalmologist or  
10 optometrist and allowing Vikas Jain to make diagnoses and determinations regarding the candidacy of  
11 some patients for Lasik surgery, acts which constitute the practice of medicine in Nevada, constituted  
12 a violation of NRS 630.305(1)(e) and accordingly Dr. Chou is subject to disciplinary action being  
13 taken against her.

#### 14 Count XII

15 64. Vikas Jain had had all of his medical licenses revoked as a result of his substandard  
16 ophthalmological Lasik performed upon at least 22 patients in Ohio who had suffered substantial  
17 harm resultant from his substandard care. Vikas Jain, therefore, had been found by a board of his peers  
18 to be unqualified to perform ophthalmic functions related to Lasik surgery.

19 65. NRS 630.305(1)(f) provides that delegating responsibility for the care of a patient to a  
20 person a licensee knows, or has reason to know, is not qualified to undertake that responsibility is  
21 grounds for initiating disciplinary action against the licensee.

22 66. Dr. Chou delegated responsibility for preoperative assessments, evaluations and  
23 diagnoses of patients' eyes to Vikas Jain, meaning that she delegated responsibility for the care of her  
24 patients to an individual who was known to be unqualified to be involved in the care of patients  
25 seeking Lasik.

26 67. Dr. Chou's delegating the responsibility for preoperative assessments and evaluations  
27 that should only be performed by a licensed ophthalmologist or optometrist and diagnosis and  
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determination of candidacy for the procedure to Vikas Jain when she knew him to be unqualified to perform such tasks constitutes a violation of NRS 630.350(1)(f).

**Count XIII**

68. NRS 630.306(2)(b) provides that engaging in conduct with the Board has determined is a violation of the standards of practice established by regulation of the Board is grounds for initiating discipline against a licensee.

69. NAC 630.230(1)(i) provides that a physician shall not fail to provide adequate supervision of a medical assistant who is employed or supervised by the physician or physician assistant.

70. Dr. Chou did not provide any, let alone adequate, supervision of any of the medical assistants at Valley Eye Center as she was only in the office on Fridays and part of Saturdays during which time she performed Lasik surgeries and some post-operative care. Dr. Chou had no involvement of the training or determining the competency of any of the medical technicians at Valley Eye Center.

71. Accordingly Dr. Chou did not provide adequate supervision to medical assistants she allowed to assist in the care of patients and thus she is in violation of NAC 630.230(1)(i) and NRS 630.306(2)(b) and is subject to discipline.

**Count XIV**

72. NRS 630.301(9) provides that engaging in conduct that brings the medical profession into disrepute is grounds for initiating discipline against a licensee.

73. Dr. Chou's acts averred in this Complaint constitute conduct that brings the medical profession into disrepute, and, thus, constitutes a violation of NRS 630.301(9) for which Dr. Chou is subject to discipline.

**Count XV**

74. NRS 630.306(7) provides that continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for initiating discipline against a licensee.

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75. Dr. Chou's acts as averred in this Complaint show a continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field while engaged in practice at Valley Eye Center for which Dr. Chou is subject to discipline.

**WHEREFORE**, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners hold a formal hearing commencing on March 29, 2010;

2. That the Nevada State Board of Medical Examiners gives Dr. Chou notice of the charges herein against her, the time and place set for the hearing, and the possible sanctions against her;

3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose for the violation or violations committed by Dr. Chou; and

4. That the Nevada State Board of Medical Examiners make, issue and serve on Dr. Chou its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 22<sup>nd</sup> day of February, 2010.

THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

Lyn E. Beggs


General Counsel and Attorney for the Investigative Committee

**CERTIFICATE OF MAILING**

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 22<sup>nd</sup> day of February 2010, I served a file copy of the SECOND AMENDED COMPLAINT, and copy of the SECOND AMENDED PATIENT DESIGNATION, by mailing via USPS regular mail to the following:

Katherine L. Turpen, Esq.  
John Cotton & Associates  
2300 West Sahara Ave., Ste. 420  
Las Vegas, NV 89102

Dated this 22<sup>nd</sup> day of February 2010.

  
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Angelia L. Donohoe  
Legal Assistant